

Appendix F

CSU Positive Drug Screen Sanctions

Student-Athlete Name _____ DOB _____

Parent or Legal Guardian Contacted? Yes _____ No (over 21 y.o.) _____

Physician/Designee Signature _____ Date _____

Counseling appointment: Date _____ Time _____

Follow Up Needed? Yes _____ No _____

Date of Next Appt. _____ Time _____

Signature of Consultant: _____

_____ has met with the Athletic Director and/or Sport Supervisor and Head Coach to discuss and review the consequences of the positive drug screen.

09/20/15 10:01 AM / AMCD 5C 022 WhB/10 029 mg 09